

Moral Distress in the Pediatric Intensive Care Unit

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1 Background

Moral distress is defined as “the pain or anguish affecting the mind, body or relationship in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action; yet, as a result of real or perceived constraints, participates in moral wrongdoing” (Nathaniel, 2006).

The PICU is a setting that is particularly vulnerable to moral distress. Clinicians on this unit routinely encounter suffering as they care for patients with suspected or confirmed life-limiting conditions. The complexities of providing this care can include the presence of multiple health-care teams who may not share opinions on trajectory of illness or treatment plans and that need to manage the expectations and wishes of the patient’s parents while providing appropriate care to the patient.

The human, financial and workforce costs of moral distress are high. Literature on moral distress in nursing staff has demonstrated that it undermines the safety and quality of patient care and contributes to burnout, staff shortages as well as fractures inter-professional relationships and thus ultimately the financial stability of the health care system (Allen et al., 2013), (DeKeyser & Berkovitz, 2012).

There is scarce literature that addresses moral distress in non-nursing staff and few studies that have investigated the root causes of moral distress. This project aims to address the gaps in understanding moral distress among inter-professional clinician teams and create an actionable, sustainable plan to address the root causes.

2 Methods

We used the grounded theory method to approach our work. The grounded theory method is a systematic methodology through which new theories can be discovered through the analysis of data. To do this work, we employed a mixed-methods approach to analyze five patients that have been the subjects of moral distress in the recent past or present (2012-present).

First, we conducted interviews with providers who cared for these patients. These informants were identified using a purposeful sampling technique. A standardized interview guide was developed by the team. We interviewed seven physicians, three nurse practitioners, ten nurses and four respiratory therapists in total. The interviews were audiotaped and transcribed.

Methods continued

Next, we performed retrospective chart reviews of these patients and created an Excel document for each patient that chronologically tracked their medical status, the patient’s pain scores as well as their sequential organ failure assessment scores. We distilled that data to identify phases of the child’s medical course such as improvement, decompensation and stability and used a scale we developed to numerically rank the patient’s acuity. This allowed us to create a trend chart for each patient.

Finally, using interview transcripts we charted informant reported instances of moral distress alongside the child’s medical course. We assessed the level of moral distress present based on frequency, plotted alongside the child’s acuity.

3 Results

Key finding:

- A child’s lack of forward progress medically is the key trigger of moral distress
- All members of the medical team experience moral distress

Findings of no correlation:

- No direct correlation between acuity of the patient’s condition and moral distress

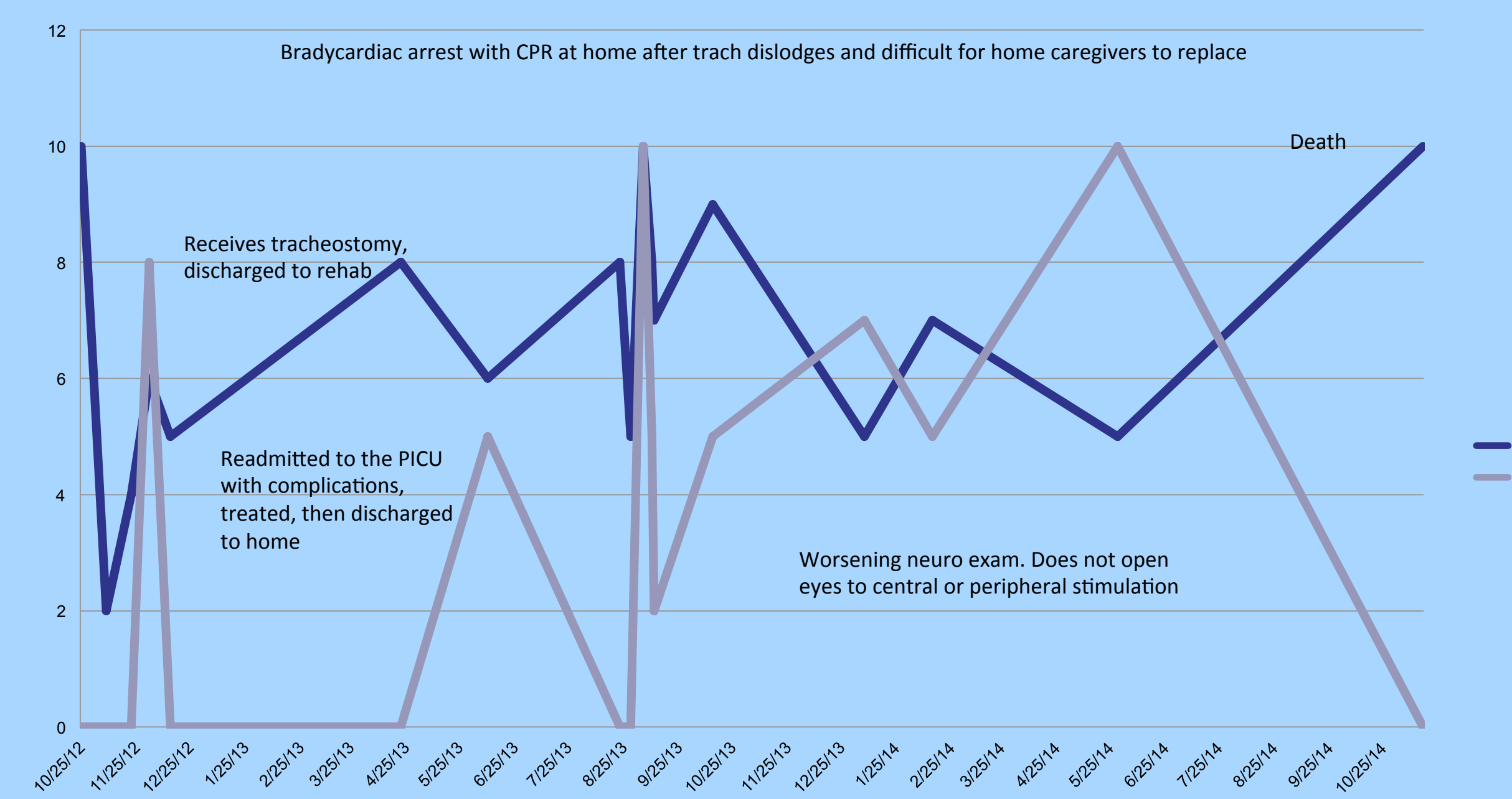
Findings of positive correlation:

- As length of stay in the PICU increases, so does the likelihood of the team experiencing moral distress
- The team’s level of moral distress rises as the dissonance between the parents and the staff’s perception of the child’s quality of life increases

Findings of negative correlation:

- The team’s levels moral distress rises when no clear goals of care are documented for the child

Moral Distress and Patient Acuity



Patient K was admitted to the PICU after she had an arrest in the MRI machine while undergoing consultation as to whether she needed a shunt placement to correct structural anomalies associated with Beckwith Weidmann variant.

4 Conclusions

Moral distress is a pervasive phenomenon in the PICU that affects all members of the clinical team. Our findings suggest that there may be characteristics surrounding the patient and their stay that trigger moral distress that can be leveraged to build early warning systems and early intervention.

5 Future Directions

More research needs to be conducted around the efficacy of trigger tools as well as interventions to relieve moral distress

6 References

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